

Alabama Medicaid Pharmacy Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36823-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____ Nursing home resident ☐ Yes

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Prescribing Practitioner Signature

Date

CLINICAL INFORMATION

Drug requested* _____ Strength _____

J Code _____ Qty. _____ Days supply _____ PA Refills: 0 1 2 3 4 5 Other _____
If applicable

Diagnosis or ICD-9 Code _____ Diagnosis or ICD-9 Code _____

☐ Initial Request ☐ Renewal ☐ Maintenance Therapy ☐ Acute Therapy

Medical justification _____

☐ **Additional medical justification attached.** **Medications received through coupons and samples are not acceptable as justification.**

*If the drug being requested is a brand name drug with an exact generic equivalent available, the FDA MedWatch Form 3500 must be submitted to HID in addition to the PA Request Form.

DRUG SPECIFIC INFORMATION

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD Agents | <input type="checkbox"/> Alzheimer's Agent | <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Antidiabetic Agent | <input type="checkbox"/> Antiemetic Agents |
| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Antihyperlipidemics | <input type="checkbox"/> Antihypertensives | <input type="checkbox"/> Antiinfective | |
| <input type="checkbox"/> Anxiolytics, Sedatives and Hypnotics | <input type="checkbox"/> Cardiac Agents | <input type="checkbox"/> EENT-Antiallergics | <input type="checkbox"/> EENT-Vasoconstrictors | |
| <input type="checkbox"/> Estrogens | <input type="checkbox"/> H2 Antagonist | <input type="checkbox"/> Intranasal Corticosteroids | <input type="checkbox"/> Narcotic Analgesics | <input type="checkbox"/> NSAID |
| <input type="checkbox"/> Platelet Aggregation Inhibitors | <input type="checkbox"/> PPI | <input type="checkbox"/> Respiratory Agents | <input type="checkbox"/> Skeletal Muscle Relaxants | |
| <input type="checkbox"/> Skin & Mucous Membrane Agent | <input type="checkbox"/> Triptans | <input type="checkbox"/> Other | | |

List previous drug usage and length of treatment as defined in instructions for drug class requested.

Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____

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If no previous drug usage, additional medical justification must be provided.

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ NPI # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____

NOTE: See Instruction sheet for specific PA requirements on the Medicaid website at www.medicaid.alabama.gov

☐ Sustained Release Oral Opioid AgonistProposed duration of therapy _____ Is medicine for PRN use? ☐ Yes ☐ NoType of pain ☐ Acute ☐ Chronic Severity of pain: ☐ Mild ☐ Moderate ☐ SevereIs there a history of substance abuse or addiction? ☐ Yes ☐ NoIf yes, is treatment plan attached? ☐ Yes ☐ No

Indicate prior and/or current analgesic therapy and alternative management choices

Drug/therapy _____ Reason for d/c _____

Drug/therapy _____ Reason for d/c _____

☐ Biological Injectables ☐ Remicade^R ☐ EnbrelTM ☐ KineretTM ☐ HumiraTM ☐ RaptivaTM ☐ Amevive^R ☐ Orencia^R
Current weight _____ kg.If rheumatoid arthritis, juvenile rheumatoid arthritis or ankylosing spondylitis, is therapy approved by a board certified rheumatologist? ☐ Yes ☐ NoPrior and/or current DMARD therapy? ☐ Yes ☐ No If yes, attach documentation.If Crohn's disease, is therapy approved by a board certified gastroenterologist? ☐ Yes ☐ NoIf Remicade^R is requested for rheumatoid arthritis, will patient be on Methotrexate? ☐ Yes ☐ No

If no, contraindication to use _____

If plaque psoriasis, is therapy approved by a board certified dermatologist? ☐ Yes ☐ NoIf psoriatic arthritis, is therapy approved by a board certified dermatologist or rheumatologist? ☐ Yes ☐ No**For Raptiva, Amevive or Enbrel**Is the patient 18 years of age or older? ☐ Yes ☐ NoIs the patient with chronic moderate to severe plaque psoriasis a candidate for systemic therapy or phototherapy? ☐ Yes ☐ NoHas the patient failed 6 month treatment trials with topicals, generic OTC or brand, within the past year? ☐ Yes ☐ No**☐ Xenical^R**☐ If initial request Weight _____ kg. Height _____ inches BMI _____ kg/m²☐ If renewal request Previous weight _____ kg. Current weight _____ kg.Documentation MD supervised exercise/diet regimen \geq 6 mo.? ☐ Yes ☐ No Planned adjunctive therapy? ☐ Yes ☐ No**☐ Phosphodiesterase Inhibitors**

Failure or inadequate response to the following alternate therapies:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Contraindication of alternate therapies: _____

☐ Documentation of vasoreactivity test attached☐ Consultation with specialist attached**☐ Specialized Nutritionals**

Height _____ inches Current weight _____ kg.

☐ If < 21 years of age, record supports that > 50% of need is met by specialized nutrition☐ If \geq 21 years of age, record supports 100% of need is met by specialized nutrition

Method of administration _____ Duration _____ # of refills _____

☐ Xolair^R

Current weight _____ kg.

Is treatment recommended by a board certified pulmonologist or allergist after their evaluation? ☐ Yes ☐ NoIs the patient symptomatic despite receiving a combination of either inhaled corticosteroid and a leukotriene inhibitor or an inhaled corticosteroid and long acting beta agonist or has the patient required 3 or more bursts of oral steroids within the past 12 months? ☐ Yes ☐ NoHas the patient had a positive skin or blood test reaction to a perennial aeroallergen? ☐ Yes ☐ NoIs the patient 12 years of age or older? ☐ Yes ☐ NoAre the patient's baseline IgE levels between 30 IU/ml and 700 IU/ml? ☐ Yes ☐ No

Level: _____ Date: _____

Is the patient's weight between 30 and 150 kg? ☐ Yes ☐ No**FOR HID USE ONLY**☐ Approve request☐ Deny request☐ Modify request☐ Medicaid eligibility verified

Comments _____

Reviewer's Signature _____

Response Date/Hour _____